RxAmerica Prior Authorization Request

Date: _____

Patient's name: _____

Patient's AHCCCS ID number: _____

Physician's name _____

Physician's phone number: ( ) _____

Physician's fax number: ( ) _____

Drug and dose requested: _____

Formulary agents already tried: _____

_____

Rationale for request: _____

_____

_____

_____

Please provide copy of chart notes.

FAX REQUEST TO *RxAmerica* AT (801) 961-6295

FOR OFFICE USE ONLY

Approved ☐ Denied ☐ Pending ☐

Rationale: _____

_____

Received: _____ Physician Notified: _____